In New York state, adjusted mortality rates for cardiac surgery have been publicly disseminated since 1990. Although some evidence exists that this programme has resulted in a lower than expected cardiac surgery mortality rate for the state, what is not clear is if public dissemination of the information was necessary. Few patients who have bypass surgery are aware of the publicly available mortality rates of their surgeon or hospital.[4] Even when they do know the rates, other factors may be more important. The hospital chosen by Bill Clinton for coronary bypass surgery, for example, had the highest mortality rate for this procedure in New York state in 2001, the most recent results available to Mr Clinton at the time of his surgery.[5] For non-cardiac procedures, most hospitals do not have sufficient case loads to compare reliably mortality at the individual hospital (let alone surgeon) level.[6]

Publication of mortality audits in this setting serves little purpose—other than, perhaps, to create a false sense of doing something to improve quality. In fact, the underlying assumption of report card programmes may be misguided; clinically significant errors are committed at all institutions and by all surgeons, not just by the outliers with poor results. To build a framework for trust, the development and systematic adoption of effective methods to minimise errors for every patient must be a priority of the entire surgical community.

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# Global functions at the World Health Organization

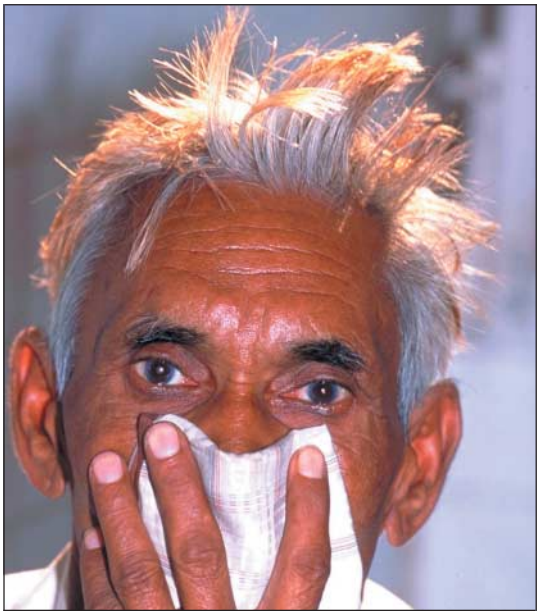
*WHO must reassert its role in integrating, coordinating, and advancing the worldwide agenda on health*

Delegates from the World Health Organization's 191 member states convene in Geneva this week to review WHO's proposed 2006-7 budget and to prioritise the organisation's core functions. This is a good time, therefore, to consider the optimal balance that WHO could strike between its global role in advocacy, surveillance, standard setting, and research as compared with its more operational work in specific countries and regions.

Accelerating globalisation has changed dramatically the context in which WHO works, offering both opportunities and challenges for health and its distribution.[1] The transfer of knowledge and technology and the sharing of best practices, treatments, and health strategies provide real benefits to previously unserved populations.[2] All countries can benefit from international standards for health and sustained advocacy on their behalf. Globalisation can also benefit health indirectly, promoting gender equality[3] and human rights[4] and better prospects for trade, information technology, and economic growth.[5]

But globalisation has also hastened the spread of infectious diseases. Moreover, aspects of global business have promoted unhealthy behaviours, such as eating unhealthy diets and using tobacco. And a major concern with globalisation remains inequalities in health[6] and other economic and social indicators,[7] both within and among countries.

WHO's work and functions are defined by its constitution and can be categorised as global, national, and intranational. Worldwide, WHO can set standards, develop and run international initiatives, provide professional management, manage financial transfers, and build scientific research capacity. It can also promote public health goods for the benefit of all. These goods include leadership and advocacy for health, instruments to protect bioethics and human rights, methods for disease surveillance, and application of standards.[8] Examples include WHO's leadership in developing the International Code of Marketing of Breastmilk Substitutes and the Framework Convention on Tobacco Control.



P VIROT/WHO

Combat tuberculosis locally, but don't forget the W in WHO stands for World

*BMJ* 2005;330:1099–100

## Pluralism in international health

The framework of international health is no longer dominated by a few organisations, and it now involves numerous players. Health debates regularly arise at gatherings of the Group of Eight Industrialised Nations (G8) and other multilateral meetings. The World Economic Forum has hosted debates on health issues, ranging from vaccines and HIV/AIDS to tobacco and obesity. A private and not for profit sector has become an important force in international health as new organisations such as the Global Fund for Aids, Malaria and TB; the Bill and Melinda Gates Foundation; and pharmaceutical companies play larger roles. More than 50 private-public partnerships, such as the Global Alliance for Vaccines and Immunization, have been established to tackle specific challenges. International non-governmental organisations, including among others Médecins Sans Frontières, Oxfam, and CARE, now work together in health emergencies and disasters and take part in policy development, and in the past two decades the World Bank has had a greater role in health development.[9]

These changes have brought many benefits for health worldwide. This pluralism, however, has also led to an increasingly fragmented, reactive, and disparate agenda for international health that needs new leadership to convene and coordinate. In this context WHO has a unique coordinating function. Its constitution gives it alone the authority to develop and implement worldwide standards and initiatives to improve health.

## WHO shifts to operational work

But now, despite a growing consensus calling for global solutions, current thinking at WHO reflects a different emphasis. To overcome the glacial pace of drug delivery to patients with AIDS and tuberculosis, WHO's director-general, Dr Lee Jong-wook, is focusing on shifting staff to countries so that they can work to enhance the distribution of treatments and build up local offices. WHO's "3 by 5" initiative, an admirable effort to increase access to antiretroviral medicines for three million people with HIV in less developed countries by 2005, exemplifies this approach.

It is hard to fault the intent behind the 3 by 5 initiative, but it does represent a marked shift away from WHO's broad based mandate and towards strategies for treatment rather than for health promotion. It emphasises the importance of operational work within countries, though this work is already being undertaken by many others.

Similarly, WHO's proposed budget for 2006-7 focuses on health interventions within countries and reinforces a shift in resources from headquarters to the regions and to WHO's presence in countries.[10] This shift implies that WHO will become more operational and less global.

## A mandate for leadership

A notable exception to these trends is the WHO Commission on Social Determinants of Health,[11] which brings together academics and practitioners to review knowledge and to promote policies to reduce global health inequalities. The commission is fulfilling WHO's agenda-setting role by identifying this issue as a priority for international cooperation and national action.

Future success in implementing WHO's global mandate will depend on considerable investments in internal expertise related to, for example, the Codex Alimentarius Commission, in which WHO and the UN Food and Agriculture Organization will establish international food standards; the crucial next steps in the Framework Convention on Tobacco Control[12]; the impacts on health of trade agreements; and efforts to implement the Global Strategy on Diet and Physical Activity.

These areas of work and others urgently need strengthening, and WHO must reassert its role in integrating, coordinating, and advancing the worldwide agenda on health. In the months ahead the executive board must discuss, openly and rigorously, WHO's core functions and mandate. The global health community will eagerly await its conclusions.

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